Race/Ethnicity and the 2000 Census: Recommendations for African American and Other Black Populations in the United States

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A B S T R A C T

This commentary considers the implications of the assessment of racial/ethnic status for monitoring the health of African Americans and other Black populations in the United States. It argues that because racial disparities in health and other social indicators persist undiminished, the continued assessment of race is essential. However, efforts must be made to ensure that racial data are of the highest quality. This will require uniform assessment of racial status that includes identifiers for subgroups of the Black population.

Research also indicates that the health of multiracial persons varies by maternal race. Thus, efforts to monitor multiracial status should assess the race of both parents. More attention should also be given to analysis and interpretation of racial data and to the collection of additional data that capture characteristics linked to race (such as socioeconomic factors and racism) that may adversely affect health. (*Am J Public Health*. 2000;90:1728–1730)

During the Office of Management and Budget (OMB) review of how race and ethnicity should be assessed, the complete elimination of any attempt to classify persons according to race was proposed.[1] It was argued that the very presence of racial categories is divisive. Some researchers have also called for the abandonment of racial categories in public health and medical research.[2,3] The government rejected these proposals, and we still have racial categories in the 2000 US census. Given the historical legacy and continuing problems of racism and discrimination, one important reason for measuring racial status is to monitor progress in reducing racial disparities in a broad range of societal outcomes. So far, federal policies designed to reduce racial inequalities have failed.

For example, the degree of residential segregation by race in the 1990 census was virtually identical to what it was when Congress passed the Fair Housing Act in 1968.[4] Other data document the persistence of racial inequality in multiple indicators of economic status. The Civil Rights Act of 1964 (Title VII) prohibited employers from firing, refusing to hire or promote, or in any way limiting an employee's compensation or job conditions because of race. However, audit studies of employment discrimination have shown that when Black and White applicants with identical qualifications apply for jobs, discrimination favors the White over the Black applicant in 1 of every 5 cases.[5]

The persistence of institutional and individual discrimination has resulted in stasis of racial inequalities in labor force participation. The *Economic Report of the President* in 1998 revealed that in 1950 the unemployment rate for Blacks was 1.8 times higher than that for Whites.[6] In 1996, the rate of unemployment among African Americans was still twice that among Whites. Similarly, between 1978 and 1996, there was no change in the racial gap in median family income. In 1978, Black households earned, on average, 59 cents for every dollar earned by White households. In 1996, Black households earned 59 cents for every dollar earned by White households.[6]

Public health data tell the same story. In 1950, the mortality rate from all causes for Blacks was 1.6 times higher than that for Whites. Mortality rates have declined for both racial groups over time, but in 1995 Blacks had a mortality rate that was, again, 1.6 times higher than that of Whites.[7] Moreover, for several of the leading causes of death (heart disease, cancer, diabetes, and cirrhosis of the liver), the gap between Blacks and Whites in death rates was larger in 1995 than it was in 1950. A similar pattern is evident in infant mortality rates over time. In 1950, the infant mortality rate for Blacks was 1.6 times higher than that for Whites. Death rates for both racial groups are considerably lower today than they were 50 years ago, but a Black infant born in 1997 was 2.4 times more likely than a White infant to die before his or her first birthday.[8]

Little progress has been made in increasing the percentage of health care professionals from underrepresented minority backgrounds. For example, Black physicians represented 2.5% of all US physicians in 1968[9]; in 1999, the percentage was 2.9%.[10] Moreover, in the wake of opposition to affirmative action programs, there has been a large drop in applications from members of underrepresented minorities to medical schools, with more than half of all US medical schools experiencing a decline in minority enrollment in 1996.[9]

As long as being Black remains consequential for every aspect of life, and as long as racial status continues to reflect differences in power and desirable resources in society, it is important to assess race. The view that we should all simply be called "Americans," and that all other race and ethnic terms should be dropped, denies the power and status differences that exist between and among racial and ethnic groups. Thus, if the welfare of the African American population and racial inequalities in society are to be monitored more broadly, it is important to continue to assess racial status. This information should be used in the effort to eliminate inequalities.

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We Need Data of the Highest Quality

Given our support for the inclusion of questions regarding racial/ethnic status in the 2000 census, we will now consider more carefully how race/ethnicity is being assessed. There are current problems with racial data in the United States that affect the quality of our information on the African American population. Census undercounts, especially for young and middle-aged Black males, are a major problem in terms of the denominators used to calculate statistics for a broad range of outcomes among African Americans.[11] Census demographic analyses indicate an undercount of 15% to 19% for middle-aged Black men.[12] Mathematically, any rate that involves a denominator with an undercount is overestimated in exact proportion to the undercount in the denominator. Thus, all rates of outcomes for middle-aged African American men in which census data are used as denominators (e.g., rates of incarceration, homicide, or AIDS) are at least 15% to 19% too high. Moreover, given that undercount estimates are available only at the national level, it is likely that undercounts of Black males are considerably higher in some large urban areas, making data for these areas even more unreliable.

Thus, a major concern with the current changes in racial classification is whether allowing persons to check multiple racial categories could lead to an even greater undercount in the denominator for the Black population. Data collected during the 1995 and 1996 tests for the 2000 census reveal that the presence of a multiracial response category did not seriously affect the percentage of persons who reported themselves as Black. This may be less true in the future. Relatedly, the preferred terms used for self-identification of racial and ethnic status change over time. Moreover, the size of the population of African descent in the United States (and that of other racial/ethnic populations) varies according to the terminology used.[13,14] This suggests the need for uniform assessment of racial/ethnic status across federal and state data systems and the larger research community. Efforts should be made to use the most preferred terms for racial populations (e.g., Black and African American) interchangeably and to periodically monitor and update racial categories.

We Need to Assess the Diversity of the Black Population

The revised OMB standard does not sufficiently take into account the diversity of the Black population. All racial populations, including persons of African descent in the United States, are characterized by considerable diversity. Black immigrants are an important part of this diversity. In the 1990 census, almost half a million persons reported sub-Saharan African ancestry.[15]

West Indians—Black immigrants from the English-speaking Caribbean basin countries—are the largest cultural group of Black immigrants. Data from the 1990 US census indicate that almost 1 million persons were of English-speaking West Indian ancestry, and an additional 300 000 were of Haitian ancestry. A recent census report estimated that 6% of the Black population is foreign born. It also estimated that at least 10% of the Black population is of foreign parentage. These rates are not trivial, and many experts believe that they are underestimates. Some estimates indicate that the subpopulation of West Indian ancestry alone constitutes at least 10% of the Black population in the United States.[16] Importantly, these numbers are larger than those of some other population subgroups that receive special attention from the federal government in terms of data collection.

An African American born and raised in the South, a Jamaican, a Haitian, a Kenyan, and an African American born and raised in the Northeast are all Black, but they are likely to differ in terms of beliefs, behavior, and perhaps even physical functioning. Such variation within the Black population also may predict important diversity in health status. This issue has not received a great deal of systematic research attention, but some data suggest that there are variations in the health status of Blacks by ethnic origin. One study showed that US-born Black women and Haitian women had higher rates of cervical cancer than West Indian women, but both West Indian and Haitian immigrant women had lower rates of breast cancer than US-born Black women.[17]

Similarly, national data from the Commonwealth Minority Health Survey indicated that Blacks of Caribbean ancestry had higher levels of stress, especially financial stress, and higher levels of psychological symptoms than US-born Blacks.[18] Given the relatively small number of Caribbean immigrants in the sample, these data have important limitations; however, they highlight the importance of paying attention to the diversity of the Black population. The OMB indicates that its guidelines are minimal standards for race classification. However, few federal agencies or other organizations go beyond OMB's guidelines and collect additional data to characterize the heterogeneity of the standard racial/ethnic categories. Because of the public health and public policy implications of racial status, higher quality data is needed.

We Need to Think Carefully About Multiracial Status

A major change in the assessment of race in 2000 and beyond is the provision that allows individuals to check more than 1 racial category. In addition to such changes at the federal level, there has been considerable multiracial legislation activity at the state level. For example, Georgia, Indiana, and Michigan require that multiracial status be included on all state forms. Illinois and Ohio, on the other hand, require identification of multiracial status on school forms.

The state legislation passed to date indicates that if a federal agency does not accept multiracial data, the state agency should classify individuals identified as multiracial by allocating them according to the racial and ethnic distribution of the general population. This would mean, for example, that in Michigan, about 85% of persons self-identified as multiracial would be classified as White in data reported by the state to federal agencies. In contrast, 1990 census data revealed that 66% of children in Black–White unions, 46% of children in American Indian–White unions, and 42% of children in Asian–White unions identified with the race of the minority parent. Accordingly, there needs to be greater coordination between the federal and state levels in terms of how multiracial status is handled.

What are the implications of multiracial status for characterizing health risks? A few studies have examined distributions of health problems by multiracial status. They have all shown that health outcomes vary by the race of the mother. For example, Collins and David[19] studied the relationship between biracial status and low-birthweight children born in Black–White unions in Illinois. In comparison with infants whose parents were White, infants born to Black mothers and White fathers had a higher rate of low birthweight than infants born to White mothers and Black fathers. Even after adjustment for maternal age, education, marital status, parity, prenatal care, census tract income, and gestational age, infants born to Black mothers and White fathers were still 1.4 times more likely to be of low birthweight than infants with 2 White parents. Similarly, using the 1983 national population of single live births, Migone et al.[20] found that among infants born in Black–White unions, low birthweight, mean birthweight, and rates of preterm births were more strongly related to the mother's than to the father's race. Biracial infants with White mothers and Black fathers had better outcomes than those with Black mothers and White fathers.

More recently, Polednak and King[21] used data from the 1991 National Linked Live Birth–Death Infant File to examine racial differences in low birthweight and prematurity. The rates of low birthweight for mothers in biracial unions were intermediate to those of Whites and Blacks. The authors found that the rate of low birthweight was higher in the Black

mother–White father group than in the White mother–Black father group. Intriguingly, there were regional differences in this pattern. The differences were smallest in the Northeast and Midwest. The smaller difference in the Northeast was due to high rates of low birthweight among the group comprising Puerto Rican White mothers and Black fathers. On the other hand, the differences were largest in the West for both rates of low birthweight and mean birthweight. Adjustment for maternal anemia, chronic hypertension, pregnancy-induced hypertension, and a broad range of demographic factors (father's education; mother's age, education, and marital status; birth order; interval from most recent pregnancy; sex of infant; maternal birthplace; point at which prenatal care was initiated; and number of prenatal visits) had little impact on the association. These data clearly suggest that if allowing persons to check more than one category is to be useful in terms of monitoring health, it is necessary to also collect data on the race of both parents.

Why does the race of the mother play such an important role? Polednak and King[21] examined distributions of demographic characteristics by biracial status. They found that there were significant differences in maternal age, maternal education, paternal education, and marriage rates between the Black mother–White father group and the White mother–Black father group. These findings highlight some of the social factors for which race is often used as a proxy and the need for researchers to be deliberate in conceptualizing and operationalizing those aspects of the social context that may be linked to race.

We Need to Think More Carefully About Race

In the final analysis, race is a socially constructed category.[22–25] We need to collect information on the relevant aspects of the social environment for which race may act as a proxy. Appropriately assessing socioeconomic status (SES) is one important place to start. SES should be comprehensively assessed[26] and should not be viewed as a substitute for race. Differences in health by SES are generally larger than racial ones.[7,27] SES may account for many of the observed racial differences in health, although it is difficult to find a definitive test of this oft-accepted relationship.[28] Priority must be given as well to identifying the multiple ways in which racism, at the level of individual and institutional behavior, adversely affects the health of nondominant racial groups.[29,30] We also need to focus more attention on the interpretation and analysis of racial data. Reporting data by race and SES together will enhance our understanding of the social factors that may be underlying disparities in health.

Knowing an individual's race tells us more about societal arrangements than about biological construction.[31] Efforts to enhance the understanding of the role of race in society must characterize the relevant societal factors that race incorporates. These efforts must begin with appropriate and comprehensive assessment of racial and ethnic status. □

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